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Issue Date: 09 January 2007

Case No.: 2005-BLA-05889

In the Matter of

L.H.

Claimant

v.

TENNCO INC.

Employer

and

OLD REPUBLIC INSURANCE CO.

Carrier

and

**DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS**

Party-in-Interest

Appearances: MARK L. FORD, Esq.
For the Claimant

DENISE DAVIDSON, Esq.
For the Employer

Before: ADELE HIGGINS ODEGARD
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §§901-945 ("the Act") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a disease of the lungs resulting from coal dust inhalation.

On May 18, 2005, this case was referred to the Office of Administrative Law Judges for a formal hearing. Subsequently, on May 19, 2006, the case was assigned to me. The hearing was held before me in Harlan, Kentucky on August 23, 2006, at which time the parties had full opportunity to present evidence and argument.

The decision that follows is based upon an analysis of the record, the arguments of the parties, and the applicable law.

I. ISSUES

The following issues are presented for adjudication:¹

- (1) whether this Claim was timely filed;
- (2) whether the Employer was properly designated as the responsible operator;
- (3) whether the Claimant suffers from pneumoconiosis;
- (4) whether his pneumoconiosis, if any, arose from coal mine employment;
- (5) whether the Claimant is totally disabled; and
- (6) whether the Claimant's total disability, if any, is due to pneumoconiosis.

II. PROCEDURAL BACKGROUND

The Claimant filed this claim for benefits on January 2, 2002 (DX 1).² On March 4, 2003, the District Director issued a proposed Decision and Order awarding benefits to the Claimant (DX 26). The Employer requested a formal hearing on March 18, 2003 (DX 27). The matter was scheduled for hearing on January 4, 2005, before Administrative Law Judge (ALJ) Thomas F. Phalen, Jr. However, during the hearing, with the agreement of the parties, ALJ Phalen decided to remand the matter back to the District Director due to newly submitted medical evidence (DX 33 at 56).

Pursuant to ALJ Phalen's Order, the matter was remanded, and additional evidence was obtained for the District Director's consideration (See DX 33 at 3). The Claimant submitted a medical report from Dr. Charles A. Moore (DX 33 at 11) and an X-ray interpretation by Dr. Michael Alexander of the Claimant's February 2002 X-ray (DX 33 at 14). The Employer submitted the deposition of Dr. Bruce Broudy (DX 33 at and X-ray interpretations by Dr. William Scott and Dr. Paul Wheeler of the Claimant's February 2002 X-ray (DX 33 at 54, 55). However, in February 2005, the District Director rejected the Employer's X-ray interpretations, on the basis that they constituted "excessive rebuttal evidence" (DX 33 at 3-4). The Employer disagreed with the District Director's decision and "moved to submit the evidence by avowal" (DX 33 at 2). The matter was re-referred to the Office of Administrative Law Judges (DX 34). The District Director did not issue a new proposed Decision and Order prior to the re-referral.

¹ The Employer did not contest the District Director's determination that the Claimant had 29 years of coal mine employment.

² The following abbreviations are used in this Opinion: "DX" refers to Director's Exhibits; "CX" refers to Claimant's Exhibits; "EX" refers to Employer's Exhibits; "T" refers to the transcript of the August 23, 2006 hearing.

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Factual Background

The Claimant was born in October 1951.³ He is married and has no dependents other than his wife. According to the records maintained by the Social Security Administration, the Claimant was employed by various coal mine operators between 1971 and 1992, and from 1994 to 2000.⁴ The Social Security Administration records reflect that the Claimant was employed by the Employer, Tennco, in 1998, 1999 and 2000, earning more than \$31,000 in 1998, more than \$24,000 in 1999 and more than \$12,000 in 2000 (DX 6). The record does not reflect any employment for the Claimant after 2000.⁵

According to the record, the Claimant had two worker compensation claims awarded based on injuries he received in 1999 and 2000, while employed by the Employer. Based on the documents contained in the record, which summarize the Claimant's compensation history, the Claimant was out of work due to his injuries between May 1, 1999 and July 11, 1999, and then again as of March 31, 2000 (DX 7).

B. Claimant's Testimony

The Claimant testified under affirmation at the hearing. He stated that he was exposed to dust on all of the jobs he worked in the mines, but the majority of his exposure would probably be rock dust because he had been a roof bolter for more than 19 years. He stated that drilling holes in the roof through the strata of the rock, in order to insert the roof bolts creates dust. There is a system to suction the dust, but sometimes it works well and sometimes it does not. The dust is a cloud, like a vapor, and it envelops the machine and the roof bolter, who is only a couple of feet from where the drilling is taking place (T. at 18-19).

The Claimant testified that he did not work at all in mining after May 2000, and that Tennco was his last employer. He worked for Tennco in 1998, 1999, and 2000, and that it went by a different name, Arjay Mining, prior to that. He started working for Arjay in 1994 and worked for Arjay through part of 1998 (T. at 19-21).

Regarding his respiratory condition, the Claimant testified that he was currently under medical treatment, with inhalers and antibiotics. He had developed pleurisy in his lungs, and the doctors were concerned he might have lung cancer, so he had a PE scan, which revealed black

³ The Claimant's date of birth is not included in his Claim. However, the Claimant gave his age and date of birth at his deposition (DX 5).

⁴ The Claimant's Social Security records reflect employment with "Cumberland Valley Contractors" and "Dynasty Resources Inc" (DX 6). According to the Claimant's claim, these were coal mine operators (DX 4). The other employers had the words "mining" or "coal" in their titles.

⁵ However, the Social Security Administration records requested were for the years up to 2000. Therefore, if the Claimant had any employment after 2000, it would not be included in the records obtained.

lung or rock dust in both lungs, but no cancer. The doctors told him that the condition was in both lungs and it was so bad that it was "just a mess" (T. at 22). According to the Claimant, his condition has become progressively worse over the last few years. Previously, the Claimant testified, he had applied through the state for a retraining incentive benefit (RIB) claim, and received an award, but he did not stop working at that time. The amount of the award, which was paid over time, was about \$5,000 (T. at 22-24).

In response to my questions, the Claimant stated that his work for Tennco was in mines in the state of Tennessee, not Kentucky. He stopped working due to a combination of back injuries over the years, plus his breathing problems. His stamina was getting bad. The company tried to find him a job that would not take as much stamina as roof bolting; they put him on the belt, but that requires a lot of lifting and shoveling, a lot of manual labor, and there were times he thought he was having a heart attack. Finally he quit because his breathing and stamina were so bad (T. at 25-26). The company paid for a special lightweight shovel for him, so that he could work on the belt line more easily, and he worked another six to eight months before he quit. Working on the belt line was dusty, and it required hard physical labor because there was a lot of lifting, possibly 80 to 100 pounds at a time, at least every other day (T. at 25-29).

The Claimant also testified that his breathing has become worse since he quit work in the mines. He stated that there are days that he feels wonderful, but he has no stamina and cannot do any physical labor, such as yard work. He has noticed that the weather affects his breathing. The inhalers, which are prescribed by Dr. Moore, help his breathing. He is under treatment from Dr. Moore for his breathing and also for his back problems. He stated that he had been injured in several incidents over the years and things just caught up with him and he could no longer do the job (T. at 29-33).

On re-direct examination, the Claimant testified that he was off work for about two and a half months in 1999 due to an injury, and worked until May of 2000. He received workers' compensation during the time he was not working due to his injury (T. at 34-35).

The Claimant also testified by deposition, in November 2002 (DX 5). In his deposition, he stated that all of his work for wages has been as a coal miner in underground mines. He testified that he began working as a miner in 1971. He recounted the names of his employers and summarized the jobs that he did in the mines. The Claimant stated that he began working for the Employer in 1998, and that he worked for the Employer until 2000, when he quit because the combination of his back injuries and his breathing problems meant that he did not have the stamina to continue to work. In approximately 1991 or 1992, he filed a state claim based on pneumoconiosis, and had received written diagnoses of simple pneumoconiosis in 1994, 1998, 1999, and 2000 (DX 5 at 3-14).

In his deposition, the Claimant testified that he did not take a physical examination before he was employed by the Employer, and stated that he had not advised the Employer that he had been diagnosed with pneumoconiosis. Nor, he testified, did the Employer ask. He worked for the Employer an average of six days per week, and did not miss work due to breathing problems. Although he saw a physician for breathing problems, the Claimant testified, he set up his medical appointments so that he did not miss work. Dr. Moore has been his physician for twelve years or

more, the Claimant stated, and he has prescribed inhalers and gave him shots from time to time as well. The Claimant testified that at the time he worked for the Employer, he saw Dr. Moore about once every two months, and he is still seeing him about that often. Dr. Moore also treats him for his back problems, and for neck problems. (DX 5 at 14-17).

The Claimant testified that he had filed a black lung claim previously, in October 2000, which was denied.⁶ He had filled out a claims form in September 2001, but chose instead to wait and file a new claim, based on his understanding that a filing in September 2001 would be a modification request. The Claimant stated that he saw Dr. Baker in conjunction with filing his state claim, years ago. The Claimant also testified that he had a CT scan of his lungs in 1998, and was told that he had silicosis. He also stated that his breathing has been getting worse since about 1991 or 1992, when he was taken off the roof bolter because he did not have the stamina and was getting dizzy spells (DX 5 at 17-25).

At his deposition, the Claimant testified that he had filed for Social Security disability payments, which he received starting in late 2000, based on his back, his neck, and his black lung. The Claimant stated that he was a smoker and was presently smoking about a pack a day; he stated he never was a heavy smoker, and smoked about $\frac{3}{4}$ of a pack per day before cutting down. Dr. Moore told him that he was “on the verge of having emphysema” about a year before, and he is still smoking (DX 5 at 18-27).

C. Timeliness of Claimant’s Claim

A claim for benefits must be filed within three years after a medical determination of total disability due to pneumoconiosis which has been communicated to the miner. §725.308(a). There is a rebuttable presumption that every claim for benefits is timely filed. §725.308(c). In this case, the Employer has controverted the timeliness of the Claimant’s filing of his claim (DX 34; T. at 15).

The evidence of record establishes that the Claimant filed state workers’ compensation claims based on injuries which occurred in 1999 and 2000 (DX 7). However, these claims relate to other injuries, and not to pneumoconiosis or any other type of pulmonary impairment. At the hearing, the Claimant testified that he filed a state retraining benefits claim in the past, relating to black lung, and received a lump sum award (T. at 22-24). In his deposition, the Claimant testified that he filed this claim in the early 1990s and that he had seen Dr. Baker prior to filing this claim, and that Dr. Baker had diagnosed pneumoconiosis. In his deposition testimony, the Claimant also stated that he had received written reports stating that X-rays had shown him to have pneumoconiosis as early as 1994. However, the Claimant did not state that he was ever informed, in writing or otherwise, that he was considered totally disabled due to pneumoconiosis.

Regarding the Claimant’s RIB claim, there is no evidence in the record that either the claim or the award is based on a finding of total disability. The Claimant did not testify that he was told that he was totally disabled due to pneumoconiosis. The Claimant did testify that

⁶ Department of Labor records indicate that the Claimant withdrew his prior claim. In accordance with §725.306(b), a withdrawn claim is considered not to have been filed.

doctors had told him that he had black lung in both lungs and it “was just a mess;” however, the Claimant did not specify when he was so informed (T. at 22).⁷

Assuming *arguendo* that the communication to the Claimant that his lungs were “just a mess” is a medical determination of disability, I find, based on the context of his testimony, that there is no evidence that this communication took place more than three years prior to the filing of the Claimant’s claim, which was in January 2002. In fact, there is no evidence that the Claimant was informed, more than three years prior to the filing of this claim, that he was totally disabled due to pneumoconiosis or any other lung condition.

Based on the foregoing, therefore, I find that there is insufficient evidence to rebut the presumption of timeliness regarding the Claimant’s claim. Consequently, I find that the Claimant’s claim was timely filed.

D. Designation of Responsible Operator

In this case, the Employer has contested its designation as the “responsible operator” (DX 34; T. at 16). The “responsible operator,” as defined in §725.495, is the potentially liable operator that most recently employed the miner. Therefore, the designation of “responsible operator” is limited to those entities which may be designated as “potentially liable operators.” Section 725.494 discusses “potentially liable operators” and requires the following: a “potentially liable operator” must have been an operator for any period after June 1973 (§725.494(b)); must have employed the miner for a cumulative period of not less than one year (§725.494(c)); must have employed the miner for at least one day after December 1969 (§725.494(d)); and must be capable of assuming financial liability for the payment of benefits (§725.494(e)). The term “operator” is defined in §725.491(a) as “(1) Any owner, lessee, or other person who operates, controls, or supervises a coal mine, or any independent contractor performing services or construction at such mine; or (2) Any other person who: ... (iii) paid wages or a salary, or provided other benefits, to an individual in exchange for work as a miner....”

The evidence of record establishes that the Employer employed the Claimant from 1998 to 2000. The Claimant testified that the Employer, Tennco, was controlled by the same individuals who owned Arjay, the coal mine operator that previously employed the Claimant from 1994 to 1998 (T. at 20-21; DX 6). The Claimant’s testimony constitutes some evidence that Tennco may be a successor operator to Arjay, as defined in §725.492.

However, it is not necessary for me to make such a determination, because I find that the record establishes that Tennco was properly designated as the responsible operator.⁸ In the

⁷ I infer, from the context of the testimony, that the Claimant was informed in this manner about the time he contracted pleurisy, which according to his testimony was about a year prior to the hearing (T. at 21).

⁸ The Claimant testified at his deposition that he was diagnosed with simple pneumoconiosis in the 1990s, prior to his employment with the Employer (DX 5 at 12-15). Under §725.494(a), there is a rebuttable presumption that a miner’s disability arose in whole or in part out of

Claimant's case, the Claimant's testimony establishes that the Employer is an operator, as defined in the regulation, and that the Employer was the last operator for whom the Claimant worked. The Claimant's social security records establish that the Employer employed the Claimant for at least a day after December 1969 (See DX 6). Using the standards set out in §725.101(a)(32), I find that the Claimant's earned wages from the Employer in the years 1998 to 2000 establish that he worked 2.63 years for the Employer, which is more than the one year that the regulation requires.⁹

E. Relevant Medical Evidence

The Claimant presented a medical report from Dr. Abdul Dahhan, dated February 2002, including the chest X-ray interpretation and pulmonary function test results that Dr. Dahhan obtained (DX 12). Dr. Dahhan conducted the pulmonary evaluation of the Claimant mandated by §725.406. In its affirmative case, the Claimant also presented X-ray interpretations by Dr. Michael Alexander (DX 33 at 14) and Dr. Enrico Cappiello (CX 1) of the Claimant's February 28, 2002 X-ray, which is the X-ray Dr. Dahhan administered as part of the Claimant's pulmonary evaluation.¹⁰

The Employer presented a medical report from Dr. Bruce Broudy, dated March 2002, as well as the transcript of Dr. Broudy's deposition, from September 2003 (EX 1).¹¹ The Employer's affirmative case also included the pulmonary function study and arterial blood gas test that Dr. Broudy administered to the Claimant.

The Employer submitted the following X-ray interpretations: in its affirmative case, the Employer presented X-ray interpretations by Dr. Paul Wheeler of the Claimant's February 28,

employment with the responsible operator. I note that the Employer has provided no evidence to rebut this presumption. I must find, consequently, that the Employer has been properly designated as the responsible operator. See Zamski v. Consolidation Coal Co., 2 B.L.R. 1-1005 (1980).

⁹ Based on the Bureau of Labor Statistics average wages for the years 1998 to 2000, I credited the Claimant with full years of employment for 1998 and 1999, and 0.63 years for 2000. Because the Bureau of Labor Statistics table in the Claimant's record listed average wages up through the year 1999, I used that year's average daily wage to compute the Claimant's employment for the year 2000 (See DX 26). The record reflects that the Claimant was out of work due to injury in 1999, and he received workers' compensation payments during the period he was unable to work. I note that the Claimant earned more than the average wage for coal mine employment in 1999, notwithstanding his several months off work due to injury, and so I credited him for a full year of employment.

¹⁰ At the hearing, Claimant's counsel indicated that he had not yet received Dr. Cappiello's interpretation of the Claimant's February 28, 2002 X-ray, and he requested that the record be held open for 30 days to submit that document. The Employer had no objection, and I authorized the late submission of the document (T. at 8). The Claimant submitted Dr. Cappiello's interpretation on September 18, 2006.

¹¹ Dr. Broudy's deposition also appears at DX 33, beginning at page 22. For the sake of consistency, I will refer to Dr. Broudy's deposition as EX 1 throughout this Decision.

2002 X-ray (EX 4) and by Dr. Thomas Jarboe of an August 23, 2004 X-ray (EX 2). To rebut the Claimant's case the Employer presented Dr. Broudy's interpretation of the Claimant's February 28, 2002 X-ray. To rebut the Director's case, which here includes Dr. Dahhan's interpretation of the February 28, 2002 X-ray, the Employer submitted an interpretation of that X-ray by Dr. Jerome Wiot (EX 3).

These items will be discussed in greater detail below.

F. Entitlement

Because this claim was filed after January 19, 2001, the Claimant's entitlement to benefits is evaluated under the revised regulations set forth at 20 C.F.R. Part 718. The Act provides for benefits for miners who are totally disabled due to pneumoconiosis. §718.204(a). In order to establish an entitlement to benefits under Part 718, the Claimant bears the burden to establish the following elements by a preponderance of the evidence; (1) the miner suffers from pneumoconiosis; (2) the pneumoconiosis arose out of coal mine employment; (3) the miner is totally disabled; and (4) the miner's total disability is caused by pneumoconiosis. Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994).

1. Elements of Entitlement:

Pneumoconiosis Defined:

Section 718.201(a) defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." This definition includes both medical or "clinical" pneumoconiosis, and statutory, or "legal" pneumoconiosis, which themselves are defined in that subparagraph at (1) and (2). "Clinical" pneumoconiosis consists of diseases recognized by the medical community as pneumoconioses, characterized by permanent deposition of substantial amounts of particulates in the lungs, and the fibrotic reaction of the lung tissue, caused by dust exposure in coal mine employment. "Legal" pneumoconiosis includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. Further, §718.201(b) states: "a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."

a. Whether the Claimant has Pneumoconiosis

There are four means of establishing the existence of pneumoconiosis, set forth at §§718.202(a)(1) through (a)(4):

- (1) X-ray evidence: §718.202(a)(1).
- (2) Biopsy or autopsy evidence: §718.202(a)(2).

(3) Regulatory presumptions: §718.202(a)(3).¹²

(4) Physician opinion based upon objective medical evidence: §718.202(a)(4).

X-ray Evidence

Section 718.202(a)(1) states that a chest X-ray conducted and classified in accordance with §718.102 may form the basis for a finding of the existence of pneumoconiosis. ILO Classifications 1, 2, 3, A, B, or C shall establish the existence of pneumoconiosis, with A, B, and C indicating the presence of complicated pneumoconiosis. See §718.304(a). Category 0, including subcategories 0/0 and 0/1, do not establish pneumoconiosis.

The record contains the following chest X-ray evidence:¹³

Date of X-Ray	Date Read	Ex.No.	Physician	Radiological Credentials ¹⁴	Interpretation ¹⁵
02/28/2002	02/28/2002	DX 12	Dahhan	B reader	ILO: 1/2; s/q; 6 zones; Size A. ¹⁶ Film quality: 1

¹² These are as follows: (a) an irrebutable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis (§718.304); (b) where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner has proven fifteen (15) years of coal mine employment and there is other evidence demonstrating the existence of totally disabling respiratory or pulmonary impairment (§718.305); or (c) a rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978 and was employed in one or more coal mines prior to June 30, 1971 (§718.306).

¹³ At the hearing, Claimant's counsel objected to my consideration of a March 26, 2002, X-ray discussed in Dr. Broudy's medical report at DX 13 and his deposition at EX 1, based on the fact that the X-ray was now missing, and he was unable to obtain a re-reading of it (T. at 6, 13). The Employer had no objection to the Claimant's proposal that I not consider Dr. Broudy's mention of that X-ray (T. at 14). Consequently, I disregard any mention of that X-ray and do not consider it in my determination of this matter.

¹⁴ A physician who is a Board-certified radiologist ("BCR") has received certification in radiology of diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Board of Radiology. See generally: http://www.answers.com/topic/radiology#after_ad1. A B reader is a physician who has demonstrated proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successful completion of an examination conducted by the National Institute for Occupational Safety and Health (NIOSH). NIOSH is a part of the Centers for Disease Control and Prevention, in the U.S. Department of Health and Human Services. See 42 C.F.R. §37.51 for a general description of the B reader program.

¹⁵ In The International Labor Organization (ILO) classification scheme, adopted by NIOSH, letters denote the size and shape of the opacities observed. Each lung is divided into three zones: upper, middle, and lower. See <http://0-www.cdc.gov.mill1.sjlibrary.org/niosh/topics/chestradiography/ilo.html>. for a general description of the classification system.

02/28/2002	06/28/2002	EX 3	Wiot	BCR, B reader	ILO: 2/2; q/t; 6 zones; Size O. Film quality: 2
02/28/2002	09/06/2006	CX 1	Cappiello	BCR, B reader	ILO: 2/2; q/p; 6 zones; Size A. Film quality: 2
02/28/2002	04/18/2003	EX 4	Wheeler	BCR, B reader	ILO: 0/1; q/q; 6 zones; Size O. Film quality: 2
02/28/2002	04/30/2004	DX 33	Alexander	BCR, B reader	ILO: 2/3; q/r; 6 zones; Size A. Film quality: 2
02/28/2002	07/21/2003	DX 33	Broudy	B reader	ILO: 2/2; q/r; 6 zones; Size O. ¹⁷ Film quality: 2
08/23/2004	04/21/2005	EX 2	Jarboe	B reader	ILO: 2/2; s/r; 6 zones; Size O. Film quality: 1

It is well established that the interpretation of an X-ray by a B reader may be given additional weight by the fact-finder. Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32, 34 (1985). The Benefits Review Board has also held that the interpretation of an X-ray by a physician who is a Board-certified radiologist as well as a B reader may be given more weight than that of a physician who is only a B reader. Scheckler v. Clinchfield Coal Co., 7 B.L.R. 1-128, 131 (1984). Additionally, a finder of fact is not required to accord greater weight to the most recent X-ray evidence of record. Rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to consider. McMath v. Director, OWCP, 12 B.L.R. 1-6 (1988); Pruitt v. Director, OWCP, 7 B.L.R. 1-544 (1984).

The X-ray evidence, summarized above, consists of six interpretations of the Claimant's February 28, 2002 X-ray (the 2002 X-ray), plus one interpretation of an August 2004 X-ray (the 2004 X-ray). Five of the six interpretations of the Claimant's 2002 X-ray are positive for pneumoconiosis. The only exception is the interpretation of Dr. Wheeler. Dr. Wheeler, who is Board-certified in radiology and is a B reader, interpreted the film as evidencing opacities in profusion 0/1, which – according to the regulation – is insufficient to support a determination of pneumoconiosis. Dr. Wheeler did, however, note opacities in all six lung zones. In his report interpreting this X-ray, Dr. Wheeler wrote the following: “Chest PA – small nodular infiltrates in lateral portion LUL>RUL and in apices mixed with tiny calcified granulomata and few tiny nodules in lateral periphery lower lungs compatible with TB or his unknown activity probably healed. No other abnormality. Light film accentuates and blurs some fine peripheral lung detail. A few small nodules could be CWP but pattern is asymmetrical and mainly in lateral periphery LUL favoring TB. Also he is young. Get CT scan for better evaluation” (EX 4).

Three other dually-qualified (Board-certified in radiology and B reader) physicians also interpreted the Claimant's 2002 X-ray. Their interpretations are summarized as follows:

¹⁶ Dr. Dahhan's interpretation was re-read for quality control purposes by Dr. E. Nicholas Sargent, a Board-certified radiologist and B reader, on April 8, 2002. Dr. Sargent rated the film as “1” in quality, and also noted the coalescence of small pneumoconiotic opacities (DX 12).

¹⁷ Dr. Broudy's report is in narrative form. It is also included as an Exhibit to his deposition (EX 1).

Dr. Cappiello observed opacities in profusion 2/2, and in all six lung zones. He determined that an opacity in “category A” was present. Under §718.304(a), opacities in category A establish complicated pneumoconiosis, as defined in the regulation. Dr. Cappiello’s report states the following: “The cardiac silhouette is not enlarged. The pulmonary vasculature is normal. There is no evidence of infiltrate. There is a large parenchymal over a centimeter in the left upper lobe. There are coalescent opacities in both upper lobes. There are many small predominantly rounded parenchymal opacities, varying in size from 3-4 mm in diameter down to a fraction of a millimeter throughout the six lung zones but favoring the four upper lung zones. There is no apparent pleural plaque or pleural thickening. Impression: Complicated pneumoconiosis with large opacity category A, small opacities q/p, 2/2. Coalescent opacities bilaterally (ax)” (CX 1).

Dr. Alexander observed opacities in profusion 2/3, present in all six lung zones, and noted that “Category A” was applicable to the size of the opacities he observed. His report stated: “Category A complicated CWP” and also noted the coalescence of opacities (box “ax” checked on the X-ray interpretation form) (DX 33).

Dr. Wiot observed opacities in profusion 2/2, present in all six lung zones. He did not, however, determine that any opacities in size “Category A” or greater were present. His report noted the coalescence of opacities (box “ax” checked on the X-ray interpretation form) but did not have any other comments (EX 3).

In addition to the dually-qualified physicians discussed above, two physicians who were B readers, Dr. Dahhan and Dr. Broudy, also interpreted the Claimant’s February 2002 X-ray. Both of these physicians observed opacities in all six lung zones; Dr. Dahhan determined that an opacity in “category A” was present; Dr. Broudy determined that no opacities in size “category A” or greater were present. Dr. Dahhan remarked in his medical report, “Q/Q (sic), 1/2 with A large opacities and coalescence.” Dr. Broudy’s report stated: “....There is diffuse interstitial nodulation in all zones, which I would categorize as category 2/2, Q/R (sic). There is definite coalescence of nodulation in the left upper lobe, but I cannot identify a definite large opacity. I would categorize the film as stage 0 for large opacities. I see no pleural disease. The lung zones are otherwise clear” (DX 33).

In addition to the various interpretations of the Claimant’s 2002 X-ray, the record contains an interpretation of a 2004 X-ray by Dr. Thomas Jarboe, who is a B reader, but not a Board-certified radiologist. Dr. Jarboe observed opacities in all six lung zones, in profusion 2/2. However, he did not observe any opacity in size “category A” or greater. His report regarding this X-ray stated the following: “....Small rounded opacities of the ‘q and r’ variety were seen in all lung zones bilaterally. The ‘q’ opacity was predominate, but there were also a significant number of ‘r’ nodules seen as well. There was a coalescence of nodules in the upper zones bilaterally, but I do not believe complicated pneumoconiosis is present. The left hilum was retracted superiorly to some extent and there was some rounding noted, suggestive of some mild adenopathy.... Impression: Radiographic evidence of simple coal workers’ pneumoconiosis. The ILO classification is 2/2, q/r, -ax. There is no definite evidence of complicated pneumoconiosis.”

Discussion

In this matter, there are multiple interpretations of the Claimant's 2002 X-ray by B readers, as well as multiple interpretations of the same X-ray by dually qualified (B reader and Board-certified radiologist) physicians. I give more weight to interpretations made by dually qualified physicians than the interpretations made by B readers. As Board-certified radiologists, these physicians have wider training and experience in X-ray diagnosis than physicians who are certified only as B readers. Consequently, I give more weight to the interpretations of Dr. Wiot, Dr. Cappiello, Dr. Wheeler, and Dr. Alexander than I do to the interpretations of Dr. Dahhan and Dr. Broudy.

Among physicians with the same level of certification (either B readers or dually-qualified physicians), I look to the relative qualifications of the physicians in determining how much weight to give to each physician's opinion. See Sexton v. Director, OWCP, 752 F.2d 213 (6th Cir. 1985). I also assess the physicians' conclusions in light of the other evidence of record, pertaining to the Claimant's medical history. Moore v. Powell Mountain Coal Co., Inc., B.R.B. No. 00-1061 B.L.A. (Sept. 18, 2001).

The Claimant presented the qualifications of Dr. Cappiello (CX 1) and Dr. Alexander (DX 33). Dr. Cappiello's qualifications establish that he was Board-certified in radiology in 1978 and specializes in diagnostic radiology. No medical school academic appointments or publications in professional journals are listed. The year of Dr. Alexander's Board certification in radiology is not provided, but the record indicates he graduated from medical school in 1978. Dr. Alexander completed residencies in nuclear medicine and diagnostic radiology, and his current specialty is nuclear medicine.

The Employer presented the qualifications of Dr. Wiot (EX 3) and Dr. Wheeler (EX 4). Dr. Wiot received his Board certification in radiology in 1959 and is an emeritus professor of radiology at the University of Cincinnati's medical school. In addition, he has served as a member of the American College of Radiology task force on pneumoconiosis since 1969 and was its chairman from 1991 to 1997. Dr. Wiot was the author or co-author of more than 50 papers dealing with diagnostic radiology, and was the co-author of several chapters in various radiology textbooks.¹⁸ Dr. Wheeler received his Board certification in radiology in 1969, and is currently an associate professor of radiology at the Johns Hopkins Medical Institutions. Like Dr. Wiot, he has been a member of the American College of Radiology Task Force on Pneumoconiosis. Dr. Wheeler also is the author or co-author of several dozen articles on radiology published in scholarly medical journals, including several on pulmonary disease.

Based solely upon the professional credentials set forth in the record, I give more weight to the conclusions of Dr. Wiot and Dr. Wheeler than to those of Dr. Cappiello and Dr. Alexander. As medical school faculty members, Dr. Wiot and Dr. Wheeler are recognized as experts who have widespread knowledge. Their authorship of articles in professional journals indicates that their expertise is acknowledged within their profession. By contrast, the

¹⁸ Dr. Wiot's listing of his credentials does not include the titles of the articles or specify the names of the publications. Nor are the titles of the textbooks to which he contributed listed.

professional credentials of Dr. Cappiello and Dr. Alexander, aside from their status as dually-qualified physicians, are not a matter of record, and I cannot presume that their expertise approaches or exceeds the demonstrated professional qualifications of Dr. Wiot and Dr. Wheeler.

Based on the evidence of record, and taking into consideration the professional credentials of the physicians who rendered interpretations of X-rays, the weight of the X-ray evidence clearly establishes that the Claimant has clinical pneumoconiosis. Five of the six interpretations of the 2002 X-ray contain conclusions that the Claimant has the disease. The sole physician who did not conclude that the Claimant had pneumoconiosis, Dr. Wheeler, observed nodules which “could be CWP,” but he also determined that these were more likely tuberculosis. As set forth above, Dr. Wheeler is one of the two physicians with the most extensive credentials. However, there is no evidence in the record that the Claimant ever had tuberculosis. The record reflects that, during their evaluations of the Claimant, both Dr. Dahhan and Dr. Broudy inquired about that disease, and the Claimant told them he had no history of tuberculosis. Dr. Dahhan’s report also reflects that the Claimant reported that no family member had tuberculosis either (See DX 12 and DX 13). Notably, there is no evidence of record that Dr. Wheeler had any information about the Claimant’s medical history when interpreting his 2002 X-ray. Specifically, it is not known whether, had Dr. Wheeler been aware that neither the Claimant nor any member of his family had a history of tuberculosis, he would have come to a different conclusion.

Consistent with the 2002 X-ray, Dr. Jarboe interpreted the 2004 X-ray as positive for pneumoconiosis. Dr. Jarboe is a B reader, and not a Board-certified radiologist. However, there is no record of an interpretation of this X-ray by a Board-certified radiologist for me to consider. Dr. Jarboe’s professional qualifications as a B reader make him well qualified to assess the Claimant’s X-ray for indicia of pneumoconiosis. Dr. Jarboe’s X-ray interpretation parallels the conclusion of the majority of the physicians who interpreted the Claimant’s 2002 X-ray.¹⁹

The weight of the X-ray evidence strongly indicates that the Claimant has pneumoconiosis. Indeed, the only dissenting voice is Dr. Wheeler, and even his report reflects the conclusion that the Claimant could have coal workers’ pneumoconiosis. I have considered Dr. Wheeler’s professional credentials, which are most impressive. In general, I give significant weight to Dr. Wheeler’s determination, based upon his professional qualifications as a medical school professor of radiology and published author of numerous scholarly articles. However, in this instance, where there is no evidence that the Claimant had a personal or family history of tuberculosis, I give less weight to Dr. Wheeler’s conclusion. Although it is possible that Dr. Wheeler observed tubercular nodules, there is nothing in the record to suggest that this is likely. Rather, the absence of any history of tuberculosis in the Claimant and his family suggests that the items Dr. Wheeler observed had a different cause. Too, I note that three other dually-qualified physicians, including Dr. Wiot, whose professional credentials as a medical school faculty member, author of professional articles on pulmonary disease, and member and past

¹⁹ In his medical report, Dr. Moore refers to this same X-ray, and states that this X-ray showed “increased disease since his last examination.” I give no weight to this statement, as I do not have any information about the radiological qualifications of Dr. Moore, nor is it clear, from Dr. Moore’s statement, upon what data his conclusion is based.

president of the American College of Radiology Task Force on Pneumoconiosis are unmatched, have concluded that the Claimant's 2002 X-ray shows him to have pneumoconiosis.

Based on the foregoing, I find that the Claimant has established, by means of X-ray, that he has pneumoconiosis.

The X-ray evidence in this Claimant's case also raises the issue of whether the Claimant has complicated pneumoconiosis. Under the regulation, a Claimant who has large opacities, one (1) centimeter in diameter or greater, equating to size "category A" or greater under the ILO standards, as observed on X-ray, has complicated pneumoconiosis. For such a Claimant, an irrebutable presumption of total disability due to pneumoconiosis applies. §718.304(a).

To summarize the physicians' opinions above regarding the 2002 X-ray, Dr. Dahhan (B reader), Dr. Cappiello (Board-certified radiologist and B reader), and Dr. Alexander (Board-certified radiologist and B reader) concluded that the Claimant has complicated pneumoconiosis, because they observed opacities in size "category A." Dr. Wiot (Board-certified radiologist and B reader), Dr. Wheeler (Board-certified radiologist and B reader) and Dr. Broudy (B reader) concluded that the Claimant does not have opacities in size "category A" or greater; of these, Dr. Wiot and Dr. Broudy noted a coalescence of opacities.²⁰

Regarding the 2004 X-ray, Dr. Jarboe did not observe opacities in size "category A" or greater, but he did note the coalescence of opacities. Indeed, a close reading of Dr. Jarboe's report indicates that Dr. Jarboe has not discounted the presence of complicated pneumoconiosis. He stated, for example, that he did not believe that complicated pneumoconiosis was present, and that there is "no definite evidence" of complicated pneumoconiosis.

The presumption that the Claimant is totally disabled due to complicated pneumoconiosis does not apply unless the Claimant establishes, by a preponderance of evidence, that he has complicated pneumoconiosis. Harris v. Old Ben Coal Co., B.R.B. 04-0812 B.L.A. (Jan 27, 2006)(en banc); see also Gray v. SLC Coal Co., 176 F.3d 382 (6th Cir. 1999). Here, the evidence of complicated pneumoconiosis is in conflict. I must resolve the conflicting evidence to determine whether the Claimant has established, by a preponderance of evidence, that he does indeed have complicated pneumoconiosis. Atkins v. Westmoreland Coal Co., B.R.B. No. 02-0877 B.L.A. (Sept. 9, 2003); see also Keene v. G & A Coal Co., Inc., B.R.B. No. 96-1689 B.L.A.-A. (Sept. 27, 1996).

Some physicians have concluded, based on X-ray interpretations, that the Claimant does have complicated pneumoconiosis; others have concluded that he does not, also based on X-ray interpretations. As noted above, the two physicians with the most extensive professional credentials are Dr. Wiot and Dr. Wheeler. Based on the 2002 X-ray, neither of them opined that the Claimant has complicated pneumoconiosis and, indeed, Dr. Wheeler's conclusion as to whether the Claimant has even simple pneumoconiosis is equivocal. Although Dr. Cappiello and Dr. Alexander both concluded that the Claimant has complicated pneumoconiosis, the record

²⁰ The coalescence of opacities indicates progression of the disease, and is generally a precursor to complicated pneumoconiosis. See Perry v. Mynu Coals, Inc., 469 F.3d 360 (4th Cir. 2006).

does not reflect that either of them has the depth of professional expertise to match either Dr. Wiot or Dr. Wheeler. Consequently, I cannot give their conclusions more weight than the conclusions of the latter. I also have considered the opinions of Dr. Dahhan and Dr. Broudy, who are B readers but not Board-certified radiologists. Both of them noted coalescence of opacities; Dr. Dahhan concluded that the Claimant had complicated pneumoconiosis, but Dr. Broudy concluded that he did not.

There is certainly some evidence that the Claimant has complicated pneumoconiosis. However, the professional credentials of the physicians who concluded that he does have complicated pneumoconiosis are not as extensive as those of the physicians who have concluded that he does not. There is certainly compelling evidence that the Claimant's lungs contained coalesced opacities; however, the mere presence of coalesced opacities does not constitute the presence of complicated pneumoconiosis, when there is no opacity in size "category A" or greater present. I cannot find, therefore, that the Claimant's 2002 X-ray establishes the presence of complicated pneumoconiosis.

The regulation recognizes that pneumoconiosis is a progressive disease. See §718.201(c). In determining whether the Claimant has established that he has complicated pneumoconiosis, I have taken into consideration the fact that the record contains an X-ray from 2004, 30 months after the 2002 X-ray. However, that X-ray, interpreted by Dr. Jarboe, a B reader, is at best equivocal for the presence of complicated pneumoconiosis. I note that Dr. Jarboe does not exclude the possibility that complicated pneumoconiosis is present, and note also that Dr. Jarboe has observed the coalescence of opacities. However, based on the fact that Dr. Jarboe did not conclude that an opacity in the size "category A" or greater is present, I find that the 2004 X-ray does not establish the presence of complicated pneumoconiosis. There is no other interpretation of the Claimant's 2004 X-ray in the record.

Because the Claimant is unable to establish that either the 2002 or the 2004 X-rays reflect opacities with a diameter of one centimeter or greater, or size "category A" or greater under the ILO system, I must find that the Claimant is unable to establish, by a preponderance of evidence, that he has complicated pneumoconiosis.

Biopsy or Autopsy Evidence

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. §718.202(a)(2). That method is not available here, as the current record contains no such evidence.

Regulatory Presumptions

A determination of the existence of pneumoconiosis may also be made using the presumptions described in §§718.304, 718.305, and 718.306. Section 718.305 is not applicable because this claim was filed after January 1, 1982. §718.305(e). Section 718.306 applies only in cases of deceased miners who died before March 1, 1978.

Section 718.304 requires X-ray, biopsy, or equivalent evidence of complicated pneumoconiosis, as defined in that paragraph of the regulation. As discussed above, there is X-ray evidence of complicated pneumoconiosis in the Claimant's case. However, I have found that the Claimant has not established, by means of X-ray, that he has complicated pneumoconiosis.

There are two additional means, under §718.304, by which a claimant can establish the existence of complicated pneumoconiosis. These are when a biopsy reveals "massive lesions in the lung" or by any other means which would be expected to yield results equivalent to either a diagnosis by X-ray or biopsy of complicated pneumoconiosis, as defined in that paragraph. In this matter, however, there is no biopsy evidence.

The Claimant has presented little evidence, other than X-ray interpretations, to attempt to establish that he has complicated pneumoconiosis. In this regard, I have considered Dr. Moore's medical report, dated December 2004, which states that the Claimant has a known case of pneumoconiosis which has been getting worse, and describes, in general terms, the results of the Claimant's August 2004 X-ray. I find Dr. Moore's report credible, based on Dr. Moore's status as the Claimant's treating physician (T. at 32; DX 5 at 16). See §718.104(d). However, I find that Dr. Moore's report is insufficient to establish that the Claimant has complicated pneumoconiosis, as the regulation defines it, because it does not suggest that the Claimant either has massive lung lesions or that an X-ray interpretation would reveal opacities of one centimeter (1 cm.) in diameter or greater. I also have considered Dr. Dahhan's medical report. However, I find Dr. Dahhan's determination that the Claimant has "complicated pneumoconiosis," which seems to be based solely on his interpretation of the Claimant's February 2002 X-ray, to be conclusory. Dr. Dahhan's medical report is discussed in greater detail below.

Weighing together all the evidence presented regarding the existence of complicated pneumoconiosis, I find that the Claimant has not established, by a preponderance of evidence, that he has complicated pneumoconiosis. Since none of these presumptions applies in this case, the existence of pneumoconiosis is not established under §718.202(a)(3). See Melnick v. Consolidation Coal Co., 16 B.L.R. 1-31 (1991)(en banc).

Physician Opinion

The fourth way to establish the existence of pneumoconiosis under §718.202 is set forth in subparagraph (a)(4): A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in §718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

A medical opinion is reasoned if the underlying documentation and data are adequate to support the findings of the physician. Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987). A medical opinion that is unreasoned or undocumented may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989). Generally, a medical opinion is well documented if it provides the clinical findings, observations, facts and other data the physician

relied on to make a diagnosis. Fields, supra. An opinion based on a physical examination, symptoms, and a patient's work and social histories may be found to be adequately documented. Hoffman v. B. & G Construction Co., 8 B.L.R. 1-65 (1985).

The record contains the following physician opinions.

Dr. Abdul Dahhan (DX 12)

In February 2002, Dr. Dahhan conducted the pulmonary evaluation of the Claimant required by §725.406 of the regulation, and issued a written report. Dr. Dahhan examined the Claimant, took a work and medical history, and administered medical tests, including a chest X-ray, pulmonary function test, and arterial blood gas test. This report reflected that the Claimant had 29 years of coal mine employment and had smoked a pack a day of cigarettes, starting at age 18, reduced to ½ pack; it also reflected that the Claimant reported daily cough with clear sputum, intermittent wheeze, and dyspnea on exertion.²¹ Dr. Dahhan's physical examination revealed no abnormalities. Dr. Dahhan, who is a B reader,²² diagnosed the Claimant with "simple and complicated pneumoconiosis" based on the Claimant's chest X-ray, which he interpreted as containing opacities in shape/size "q/q," profusion 1/2, in all six zones, large opacities in size "A," and coalescence.

Dr. Charles Moore (DX 33 at 11)²³

The Claimant submitted the medical report of Dr. Charles Moore, his treating physician, dated December 2004. In his report, Dr. Moore stated that the Claimant had "a known case of pneumoconiosis for multi years," and asserted that the disease continued to progress "as evidenced by increased shortness of breath, and decreased endurance." Dr. Moore also noted that a chest X-ray done in August 2004 showed "extensive diffuse bilateral reticulo-nodular infiltrates" consistent with pneumoconiosis, "with increased disease since his last examination" (DX 33 at 11).

Dr. Bruce Broudy (DX 13; DX 33 at 22; DX 33 at 38)

At the request of the Employer, Dr. Broudy, who is Board-certified in internal medicine and pulmonary medicine and is a B reader, conducted an evaluation of the Claimant in March

²¹ Dr. Dahhan's report reflects that he considered the Claimant's statement of coal mine employment, form CM-911 or equivalent, dated January 2, 2002, but the Claimant's form is not attached to Dr. Dahhan's report. In his coal mine employment history form, which is in fact stamped as received January 2, 2002 (though dated several days before), the Claimant listed multiple employers and a coal mine employment history from 1971 to 2000 (see DX 3).

²² The record does not contain any other information regarding Dr. Dahhan's professional qualifications.

²³ The Claimant did not include Dr. Moore's report in his pre-hearing statement. However, the Claimant's pre-hearing statement does not list any medical reports the Claimant intended to present in his affirmative case. Therefore, my consideration of this report does not violate the regulatory limitations on evidence. See §725.414(a).

2002 and issued a written report. Dr. Broudy's evaluation included a physical examination, the taking of a medical and work history, and the administering of various medical tests, including a chest X-ray, a pulmonary function study, and an arterial blood gas test. Dr. Broudy's written report, which presumes a coal mine employment history of 30 years and a smoking history of more than 30 years (since age 18 or 19 at a pack per day, recently reduced to ½ pack per day), reflected that the Claimant reported shortness of breath on exertion, wheezing, and sleep trouble due to breathing problems. However, Dr. Broudy noted no physical abnormalities relating to the Claimant's respiratory system. His written report reflects that Dr. Broudy diagnosed the Claimant with simple coal workers' pneumoconiosis.²⁴

In July 2003, Dr. Broudy interpreted the Claimant's February 28, 2002 X-ray and submitted a narrative report. Dr. Broudy's report indicated that he observed "diffuse interstitial nodulation in all zones," which he classed as category 2/2 in profusion, with opacities of shape and size q/r. Dr. Broudy also noted "definite coalescence of nodulation in the left upper lobe, but I cannot identify a definite large opacity." He would categorize the film as stage O for large opacities.

In September 2003, Dr. Broudy testified by deposition. He discussed his interpretation of the Claimant's February 28, 2002 chest X-ray, and testified that the film quality was acceptable for interpretation. He also testified that he did not observe any characteristics of complicated pneumoconiosis in that film. Dr. Broudy testified that the results of the pulmonary function studies he administered to the Claimant were basically normal; and that the Claimant did not have obstructive pulmonary disease, because he did not have a reduction in the ratio of FEV₁ to FVC. He also testified that the Claimant's arterial blood gas test results were normal. Dr. Broudy testified that, based upon the Claimant's test results, he concluded that the Claimant retained the capacity to work underground in the two jobs he considered, roof bolter and "on the belt line."

Discussion

All of the physicians who wrote medical reports concluded that the Claimant had pneumoconiosis.²⁵ Dr. Dahhan determined that the Claimant had simple and complicated pneumoconiosis, and Dr. Broudy concluded that he did not have complicated pneumoconiosis, but did have simple pneumoconiosis. These physicians, both of whom were B readers, interpreted the Claimant's 2002 X-ray differently. Although I do not differentiate between the two physicians based upon their radiological qualifications (both having equivalent credentials as B readers), I give more weight to Dr. Broudy's opinion, based upon his qualifications as a Board-certified physician in internal medicine and pulmonary medicine. I also give more weight to his opinion, based on the fact that the evidence indicates that Dr. Broudy has considered more than just the Claimant's X-ray results in coming to a conclusion. Notably, based on physical examination and the results of objective medical tests, Dr. Broudy has determined that the

²⁴ This diagnosis was made on the basis of an X-ray that has since been lost, and I do not consider any determination based on such evidence. See T. at 14-15.

²⁵ Documents which consist solely of interpretation of an X-ray are not considered medical reports. §725.414(a)(1).

Claimant has no pulmonary impairment, and no other respiratory ailment such as chronic obstructive pulmonary disease. Nevertheless, Dr. Broudy has opined that the Claimant has pneumoconiosis.

I give little weight to Dr. Dahhan's conclusion that the Claimant has complicated pneumoconiosis, as it appears to be based entirely upon Dr. Dahhan's X-ray interpretation. (Dr. Dahhan does not provide an explanation for his conclusion, but did interpret the Claimant's X-ray as evidencing complicated pneumoconiosis). As discussed earlier, I have found that the weight of the X-ray evidence does not establish that the Claimant has complicated pneumoconiosis. Likewise, I give little weight to Dr. Dahhan's conclusion that the Claimant has simple pneumoconiosis, because Dr. Dahhan provided no explanation as to how he arrived at that conclusion in his medical report. I also give little weight to Dr. Moore's opinion. I note that Dr. Moore is the Claimant's treating physician, as the Claimant testified that he has been seeing Dr. Moore for treatment for a number of years. However, Dr. Moore's professional credentials are not a matter of record; additionally, his report does not provide any information about the basis for the diagnosis of a "known case of pneumoconiosis" (DX 33 at 11). Consequently, I am unable to determine whether Dr. Moore's determination is credible or not.

As set forth above, I have already found that the Claimant has established, through X-ray evidence, that he has pneumoconiosis. Based on the evidence presented, as well as the absence of evidence contradicting that conclusion, I find that the Claimant also has established, by a preponderance of evidence, that he has pneumoconiosis, based on physician opinion.

b. Whether the Pneumoconiosis "Arose out of" Coal Mine Employment

Under the governing regulation, a miner who was employed for at least ten years in coal mine employment is entitled to a rebuttable presumption that pneumoconiosis arose out of coal mine employment. §718.203(b). As set forth above, the Employer did not contest the District Director's determination that the Claimant had 29 years of coal mine employment. I find that the record supports the District Director's determination, and that the Claimant has established 29 years of coal mine employment.

Based on the foregoing, the Claimant is entitled to the benefit of the rebuttable presumption. As set forth above, I have found that the Claimant has established, by a preponderance of evidence, that he has pneumoconiosis. The Employer has not presented any evidence to rebut the presumption. Consequently, I find that the Claimant has established, by a preponderance of evidence, that his pneumoconiosis arose out of his coal mine employment.

c. Whether the Claimant is Totally Disabled

The Claimant bears the burden to establish that he is totally disabled due to a respiratory or pulmonary condition. Section 718.204(b)(1) states that a miner shall be considered totally disabled "if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner: (i) from performing his or her usual coal mine work; or (ii) from engaging in gainful employment . . . requiring the skills and abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over

a substantial period of time.” Nonpulmonary and nonrespiratory conditions, which cause an “independent disability unrelated to the miner’s pulmonary or respiratory disability” shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. §718.204(a). See also Beatty v. Danri Corp., 16 B.L.R. 1-11 (1991).

The regulation provides that, in the absence of contrary probative evidence, the following may be used to establish a miner’s total disability: pulmonary function tests with values below a specified threshold; arterial blood gas tests with results below a specified threshold; a finding of pneumoconiosis with evidence of cor pulmonale with right-sided congestive heart failure. §718.204(b)(2)(i)(ii) and (iii). Where the above do not demonstrate total disability, or appropriate medical tests are contraindicated, total disability may nevertheless be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner’s respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine employment. §718.204(b)(2)(iv).

Pulmonary Function Tests

The record contains the following pulmonary function test results:

Date of Test	Physician	FEV ₁	FVC	MVV	FEV ₁ /FVC Ratio	Valid ?
02/28/2002	Dahhan	2.91	3.41	83.00	85%	Yes ²⁶
03/26/2002	Broudy	2.67	3.15	82	85%	Yes

In order to demonstrate total respiratory disability on the basis of the pulmonary function tests, the studies must, after accounting for gender, age, and height, produce a qualifying value for the forced expiratory volume [FEV₁] test and at least one of the following: a qualifying value for the forced vital capacity [FVC] test; a qualifying value for the maximum voluntary volume [MVV] test; or a value of the FEV₁ divided by the FVC that is less than or equal to 55%. §718.204(b)(2)(i). “Qualifying values” for the FEV₁, FVC, and the MVV tests are results measured at less than or equal to the values listed in the appropriate tables of Appendix B to Part 718.

The Claimant was born in October 1951, so at the time of the pulmonary function tests listed above he was 50 years old. His height was variously recorded as 161 centimeters (which equates to 63.38 inches) and 63 inches. I find, based on the record, that he is at least 63 inches tall. At this height, the qualifying FEV₁ value at age 50 is 1.82.

Neither of the Claimant’s pulmonary function tests resulted in qualifying values. Consequently, the Claimant is unable to establish, by means of pulmonary function tests, that he is totally disabled.

²⁶ The record contains three flow-volume loops, as required by Appendix B to Part 718. However, at least two of the flow-volume loops, including the flow-volume loop relating to the trial recorded above, are incomplete (that is, the loop does not close entirely).

Arterial Blood Gas Tests

The record contains the following arterial blood gas test results:

Date of Test	Physician	PCO ₂	PO ₂	PCO ₂ (post-exercise)	PO ₂ (post-exercise)
02/28/2002	Dahhan	38.1	83.7	37.5	85.2 ²⁷
03/26/2002	Broudy	35.6	83.4	Not done	Not done

A Claimant may also establish total disability based upon arterial blood gas tests. In order to establish total disability, the test must produce a qualifying value, as set out in Appendix C to Part 718. §718.204(b)(2)(ii). Appendix C lists values for percentage of carbon dioxide [PCO₂] and percentage of oxygen [PO₂], based upon several gradations of altitudes above sea level. At a specified gradation (e.g., 2999 feet above sea level or below), and PCO₂ level, a qualifying value must be less than or equivalent to the PO₂ listed in the table.

The altitude at which the first arterial blood gas test was administered was less than 2999 feet. The altitude at which the second test, in March 2002, was administered is not noted in the record, but I presume it was less than 5999 feet.²⁸ The Claimant's PCO₂ value for the first test was 38.1 at rest and 35.7 after exercise; corresponding qualifying PO₂ values are 62 and 63. The Claimant's PCO₂ value for the March 2002 test was 35.6: a qualifying PO₂ value at an altitude of 0-2999 feet is 65 and at an altitude of 3000-5999 feet the qualifying value is 60.

Neither of the Claimant's arterial blood gas tests reflect qualifying values. Consequently, he is unable to establish, by means of arterial blood gas testing, that he is totally disabled.

Cor Pulmonale

A miner may demonstrate total disability with, in addition to pneumoconiosis, medical evidence of cor pulmonale with right-sided congestive heart failure. §718.204(b)(2)(iii). As stated above, I have found that the Claimant has established the existence of pneumoconiosis. However, there is no evidence of cor pulmonale with right-sided congestive heart failure. Accordingly, I find that the Claimant has not established total disability under this provision.

Physician Opinion

The final method of determining whether the Claimant is totally disabled is through the reasoned medical judgment of a physician that the Claimant's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable gainful employment.

²⁷ The record of this test states that the Claimant exercised for three minutes and that the test was terminated due to his dizziness.

²⁸ Per 29 C.F.R. §18.201, judicial notice may be taken of adjudicative facts. The highest point in Kentucky is 4145 feet. See: <http://www.geology.com/states/Kentucky.shtml>.

Such an opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. §718.204(b)(2)(iv). A reasoned opinion is one that contains underlying documentation adequate to support the physician's conclusions. Fields v. Island Creek Coal Co., 10 BLR 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. Id. An unreasoned or undocumented opinion may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 BLR 1-149, 1-155 (1989). In order for a physician's opinion to be well-reasoned, the physician must demonstrate an understanding of the exertion required in the Claimant's last coal mine job. Brigance v. Peabody Coal Co., B.R.B. No. 05-0722 B.L.A. (June 9, 2006)(en banc).

Dr. Dahhan, who administered the pulmonary evaluation required under §725.406, determined that the Claimant had no functional respiratory impairment, and retained the capacity to continue his previous coal mine employment. Dr. Moore's written report did not address whether the Claimant was disabled from employment, though it did state that the Claimant's physical symptoms from his disease were increasing. In his written report, Dr. Broudy stated that there was no evidence of pulmonary disability or chronic obstructive lung disease in the Claimant. He noted that the Claimant's pulmonary function study was basically normal, except for the MVV value, which could be related to suboptimal effort, and that the Claimant's arterial blood gas test results also were normal. Dr. Broudy concluded that the Claimant retained the pulmonary capacity to perform the work of an underground coal miner or perform similarly arduous manual labor. In his deposition testimony, Dr. Broudy reiterated this conclusion, stating that he was generally familiar with the job requirements of working as a roof bolter or on the beltline, and he determined that the Claimant retained the respiratory capacity to perform either of those jobs.

In the Claimant's case, no physician has offered an opinion that the Claimant is totally disabled from performing the work of a coal miner. The record reflects that the Claimant informed Dr. Broudy that he had worked on the beltline, in general labor, and as a roof bolter in the mines. The record regarding the basis of Dr. Dahhan's knowledge of the Claimant's coal mine employment, and thus the exertional requirements of that employment, is incomplete in that the page listing the Claimant's employment, and which is noted as attached to Dr. Dahhan's report, is not present. Based, however, on the fact that Dr. Dahhan's report notes that a listing of the Claimant's coal mine employment is attached, I presume that Dr. Dahhan considered that listing, which indicated that the Claimant most recently operated a shuttle car and did general labor.

Based on the foregoing, where there is no physician opinion concluding that the Claimant is totally disabled, and there is evidence that the physicians who rendered opinions, Dr. Dahhan and Dr. Broudy, considered the Claimant's jobs in making their determinations, I find that the Claimant is unable to establish, by means of physician opinion, that he is totally disabled. Based on the fact that the Claimant was unable to establish that he is totally disabled by any other means recognized in §718.204 of the regulation, I also find that the Claimant is unable to establish, by a preponderance of evidence, that he is totally disabled.

d. Whether the Claimant's Disability is Due to Pneumoconiosis

Lastly, the Claimant must establish that he is totally disabled due to pneumoconiosis. This element is fulfilled if pneumoconiosis, as defined in §718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. §718.204(c); Grundy Mining Co. v. Flynn, 353 F.3d 467 (6th Cir. 2004); Lollar v. Alabama By-Products Corp., 893 F.2d 1258 (11th Cir. 1990). The regulations provide that pneumoconiosis is a "substantially contributing cause" of the miner's disability if it (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. A Claimant can establish this element through a physician's documented and reasoned medical report. §718.204(c).

As the discussion above indicates, the Claimant is unable to establish that he is totally disabled. Consequently, I must find that he is unable to establish, by a preponderance of evidence, that he is totally disabled due to pneumoconiosis.

IV. CONCLUSION

Based upon applicable law and my review of all of the evidence, I find that the Claimant has not established his entitlement to benefits under the Act. Although the Claimant has established that he has pneumoconiosis, and that his pneumoconiosis arose out of his coal mine employment, he has not established that he is totally disabled due to pneumoconiosis. As discussed above, the Claimant is unable to establish that he has complicated pneumoconiosis as defined in §718.304, and so he is unable to benefit from the irrebuttable presumption of total disability due to pneumoconiosis that such a finding brings.

V. ATTORNEY'S FEE

The award of an attorney's fee is permitted only in cases in which a Claimant is represented by counsel and is found to be entitled to benefits under the Act. Because benefits were not awarded in this Claim, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the Claim.

VI. ORDER

The Claimant's Claim for benefits under the Act is DENIED.

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Adele H. Odegard
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. §802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. §725.481.